Revised 12-2011

STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR HEALTH CARE COVERAGE

Reset Form | Print

A. REASON FOR APPLICATION

☐New coverage
☐Change coverage
☐Information change
☐Medicare Eligible
☐Refuse coverage *(see Section E)*

ADD DEPENDENTS DUE TO:
Date of event checked: ____________
☐ Marriage/Civil Union
☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship

CANCEL DEPENDENTS DUE TO:
Date of event checked: ____________
☐Divorce ☐ Death
☐Over age ☐ Other
☐No longer dependent

REINSTATE COVERAGE DUE TO:
Date of event checked: ______________
☐Administrative error
☐Other

B. PERSONAL INFORMATION

☐ Male ☐ Female	☐ Retiree ☐ Surviving spouse	☐ Non-employee	Date of Retirement (month, day, year)	Social Security Number	Agency or School District PENSION OFFICE

Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)

Street Address	City	State	Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Individual ☐ Individual & Spouse ☐ Individual & child (ren) ☐Family

**Relationship of Spouse applies to Spouse or Civil Union Spouse*
**Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)*

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:

☐ BCBS First State Basic ☐Blue Care (HMO) ☐Aetna (HMO) ☐BCBS Comprehensive
☐ BCBS Consumer Directed Health Gold ☐Aetna Consumer Directed Health Gold

OR

MEDICARE SUPPLEMENT COVERAGE CHOICE:

☐BCBS Special Medicfill with prescription ☐Special Medicfill without prescription

MEDICARE INFORMATION: Must enroll if eligible
Please include copy of Medicare card with this application.

Applicant's Medicare #: ______________________

Part A Effective Date: ______________________

Part B Effective Date: ______________________

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

***If you choose Blue Care (HMO) coverage or Aetna, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents**
If more space Is needed to list dependents, please use a separate sheet of paper and attach It to this application.

Name of Your Pri mary Care Physician	Physician's ID Number	Is this your current physician? ☐YES ☐NO

☐Add ☐ Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐I am ☐My spouse ☐My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Blue Cross Blue Shield contract? ☐Y ☐N

F. TERMS OF AGREEMENT

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Blue Cross Blue Shield of Delaware (BCBSD) or Aetna. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to BCBSD or Aetna, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize BCBSD or Aetna to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I **ELECT** to participate in the State Health Insurance and do agree to the above terms.

Signature:____Date:______________

I elect **NOT** to participate in the State Health Insurance.

Signature: ______________________________________Date:________________